South Carolina Department of Health and Human Services
MEDICAID ADDENDUM FOR INSTITUTIONAL/WAIVER SERVICES

☐ **Nursing Home** ☐ **Waiver Services**

This form is used to gather other information needed to make a decision about eligibility for Nursing Home or Waiver Services. All of the rights and responsibilities agreed to when the original application was signed are still in effect. If there are any questions about those rights and responsibilities, please talk to the eligibility worker who sent this form to you for a complete explanation.

1. Who is the person needing assistance (applicant)?

Name (First, Middle Initial, Last):	**Social Security Number**	**Date of Birth**

2. Where is the person right now? ☐ **Home** ☐ **Hospital** ☐ **Nursing Home** ☐ **Other**

If not at Home, tell us where the person is.

Name of Facility or Hospital: _____

Date Entered: _____

3. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant.

If yes, please give us a copy of the legal papers and the name and phone number of the person.

☐ Conservatorship Name: _____

☐ Guardianship Name: _____

☐ Power of Attorney Name: _____

4. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to spouse remaining at home? ..... ☐ **Yes** ☐ **No**

5. If there are dependent children or dependent adult, does the applicant want to give (allocate) income to the dependent children or dependent adult? ..... ☐ **Yes** ☐ **No**

6. Has the applicant or spouse ever worked somewhere that has a retirement benefit for which he or she may be eligible to receive money? ..... ☐ **Yes** ☐ **No**

If yes, who was working,where and for how long? _____

7. Does anyone have a bank account, or any other asset, for the applicant or spouse? ... ☐ **Yes** ☐ **No**

If yes, at what bank or location, and in whose name(s)? _____

_____

8. Has the applicant or spouse closed any bank accounts in the past five (5) years? ..... ☐ **Yes** ☐ **No**

If yes, at what bank and in whose name(s)?

A. _____

_____

_____

Date Closed: _____

Closing Balance: _____

B. _____

_____

_____

Date Closed: _____

Closing Balance: _____

9. Has the applicant or spouse sold or given as a gift, any cash, property, vehicle, boat or other resource to any person any time in the past five (5) years? ..... ☐ Yes ☐ No

Item Sold or Given Away	Person to Whom it was Sold or Given	Date Given or Sold	Amount Received

10. Where has the applicant lived in the past five (5) years?

City	County	State	From	To

11. If ever married, give the following information about the applicant's spouse(s). *(List the most recent first.)*

Name:

☐ Living
- ☐ In a medical facility
- ☐ Married living together
- ☐ Married living apart (Not Separated)
- ☐ Separated – When or How long? _____
- ☐ Divorced Date and State/County where filed: _____

Current Address: Phone Number:

☐ Deceased Date of Death: _____
State and County where estate was probated:

Name:

☐ Divorced Date and place divorce filed:
☐ Deceased Date of Death:
State and County where estate was probated:

Name:

☐ Divorced Date and place divorce filed:
☐ Deceased Date of Death:
State and County where estate was probated:

12. Give the following information about the applicant's mother and father, if known.

Mother:

☐ Living Address:

Phone Number:

☐ Deceased

Date of Death: _____
County and State where estate was probated:

Father:

☐ Living Address:

Phone Number:

☐ Deceased

Date of Death: _____
County and State where estate was probated:

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE.)

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

Signature of person completing this form:	**Relationship:**

FOR SCDHHS USE ONLY

Verifications in File:	☐ DHHS 1255 ME ☐ DHHS 1253 ME	**Level of Care Verified:**	☐ Intermediate ☐ Skilled ☐ SNF
Checked for Transfers:	☐ Yes ☐ No	**Were any Transfers Discovered:**	☐ Yes ☐ No

Calculated Sanction Period:

Burial Exclusion for: _____

Pre Need Burial Contract

Name of Funeral Home: _____ ☐ Irrevocable ☐ Revocable

Burial Space Items: $_____ Burial Fund Items: $_____ Date of Contract: _____

Burial Fund Exclusion List the Asset(s) Designated for Burial and the Value:

_____

Total Amount Designated: $_____ Excluded: $_____ Non Excluded: $_____

I UNDERSTAND THAT IF ANY EXCLUDED BURIAL FUNDS ARE USED FOR ANY PURPOSE EXCEPT BURIAL, AN AMOUNT EQUAL TO THE AMOUNT USED FOR SOME OTHER PURPOSE WILL BE COUNTED AS INCOME IN DETERMINING ELIGIBILITY FOR ASSISTANCE.

SIGNATURE: _____ **DATE:** _____